ALIVIO PAIN & INJURY RECOVERY CENTER

A Team of Doctors Working Together for Your Relief Of Back, Muscle and Joint Pain

Must be completely filled out in order to qualify

Name: _____ Age: _____
Address: _____
City: _____ State: _____ Zip: _____
Cell #: _____
Work #: _____
Employer: _____

Please Check any of the following health concerns:

- ☐ Asthma
- ☐ Headaches/Migraines
- ☐ Arthritis
- ☐ Neck Pain
- ☐ Menstrual Pain
- ☐ Allergies/Sinus Troubles
- ☐ Shoulder/Arm Pain
- ☐ Problem Sleeping
- ☐ Leg or Hip Pain
- ☐ Carpal Tunnel
- ☐ Sciatic Pain
- ☐ Depression
- ☐ Mid/Low Back Pain
- ☐ Digestive Problems
- ☐ Low Energy

Are any of these health problems a result of a recent accident or injury?

- ☐ Yes
- ☐ No

If you qualify, best time to call?

- ☐ AM
- ☐ PM
- ☐ Anytime

Applicants will be contacted by phone or email